**PHARMACY PROFILE: HALOPERIDOL**

**Key Messages**

- In palliative care, haloperidol is usually used in the management of delirium, nausea and vomiting.
- Through blocking of dopamine receptors, haloperidol can commonly contribute to adverse effects such as drowsiness, akathesia and hyperprolactinaemia.
- Notify the prescriber if severe muscle rigidity and fever develop.

Haloperidol is an antipsychotic and acts mainly through blocking dopamine receptors throughout the body. In palliative care, it is used predominantly to manage delirium, nausea and/or vomiting. The use of haloperidol can reduce the medication burden in the terminal phase by managing multiple symptoms at once, as death approaches. Delirium can result from a range of acute insults (e.g. infection, opiates) and these should be investigated unless the patient is clearly in the terminal phase. As with metoclopramide, haloperidol is useful for the treatment of nausea that is mediated by dopamine. Dopamine is found predominantly in the Chemoreceptor Trigger Zone (CTZ) within the brain and the gastrointestinal tract.

The half-life of haloperidol ranges from 7 to 13 hours. When used to manage nausea, lower doses administered once or twice a day are usually appropriate. When used to manage delirium, it may be required more frequently, or in higher doses, to provide around-the-clock coverage of symptoms.

Haloperidol is available on the Australian [Pharmaceutical Benefits Scheme](https://www.pbs.gov.au) in a variety of oral solid, liquid and injectable forms. This makes it both affordable and practical at all stages of the illness trajectory (including the last few days of life where dysphagia is an issue).

**Nursing Assessment**

Because haloperidol antagonises dopamine, it should be used with caution with other medicines that act on (or against) dopamine receptors. Where possible, it should be avoided in patients with Parkinson's disease.

**Administration Points**

Following subcutaneous administration, haloperidol's onset of action can be as quick as 10 minutes. The onset of action may take up to an hour after oral administration.

Haloperidol comes commercially as an oral liquid formulation and this is practical for patients with swallowing difficulties. Where the liquid is unavailable, haloperidol tablets may be crushed and dissolved in a small volume of water - it may take a few minutes for the tablet to completely dissolve. For people who are vomiting or are in the terminal phase, the subcutaneous route – either as a bolus or continuous infusion – may be more practical.
**Monitoring**

As haloperidol acts against dopamine receptors, the adverse effect profile is similar for metoclopramide. In addition, haloperidol influences the adrenergic system and may contribute to postural hypotension. Common adverse effects include drowsiness, akathesia, dizziness and hyperprolactinaemia (resulting in galactorrhoea, gynaecomastia and amenorrhoea). Extrapyramidal effects appear to be more common with haloperidol (compared with alternative antipsychotics) and include:

- Dystonic reactions - characterized by involuntary muscle contractions leading to slow repetitive movements or abnormal postures;
- Parkinsonism; and
- Tardive dyskinesia - encompasses involuntary movements of the face, mouth or tongue and sometimes head and neck, trunk or limbs.

Akathesia is an umbrella term that is used to describe a range of symptoms including inner restlessness, uncontrollable movements including rocking and marching on the spot. This is dose related and it is more likely after several (therapeutic) doses are administered in a row. Informing the prescriber when akathesia presents can make sure the order is reviewed at once.

Neuroleptic malignant syndrome is a serious (and rare) adverse effect associated with severe muscle rigidity and fever. The prescriber should be notified immediately, if these symptoms develop.

**Useful Resources**

- Contact your local pharmacist or hospital drug information service.

*This update is intended to provide practical up to date information relating to medicines management in the setting of Palliative Care and is based on critical review of available evidence. Individual patient circumstances must be considered when applying this information*

Author: Paul Tait, Palliative Care Pharmacist, Southern Adelaide Palliative Services, Adelaide SA.